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CORRESPONDENCE

Letter to the Editor re: "Preoperative radiological assessment for vascular access". *Eur J Vasc Endovasc Surg* 2006;31:64–69

Sir,

We have a number of reservations with Dr Brown's statement in his recent review article that "studies provide convincing evidence for the routine use of preoperative duplex scanning prior to AVF formation". Papers that report the benefits of ultrasound are not randomised; the incidence of AVF formed was compared before and after the introduction of preoperative scanning. However, ultrasound was introduced at a time of increasing emphasis on formation of AVF because prosthetic grafts were recognised as being a much inferior modality for providing haemodialysis. There is no evidence that the use of ultrasound actually increases the number of *wrist* fistulae formed. Instead, the adoption of a minimal acceptable venous diameter of 2.5 mm may preclude the use of wrist cephalic veins that would have been acceptable on clinical examination; most studies report that following the introduction of ultrasound, wrist fistulae were formed in only 15 to 30% of patients.

We instead use ultrasound selectively, for the small group of patients whose forearm venous anatomy can't be defined by clinical examination.[1] This has resulted in patency rates comparable to studies that use ultrasound routinely, but in contrast, wrist fistulae were formed in over 80% of cases. In approximately 1/3 of these, the cephalic vein was less than 2.5 mm but nevertheless suitable on clinical examination and our results reinforce those of Patel which suggest that the ability to distinguish useable veins may be greater using clinical criteria than an ultrasonically-defined minimum diameter.[2]

Furthermore, using ultrasound selectively minimises delay between assessment and surgery; most patients can have definitive access surgery planned simply on the basis of clinical examination. This has allowed the introduction of a one-stop vascular access service. We are confident that this approach will allow us to meet UK Renal Association Guidelines that recommend no patient should wait longer than 4 weeks for surgery and will also limit the number of patients commencing dialysis with a temporary line.

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The saphenous veins – great and small or long and short?

The international consensus statement on nomenclature of lower limb veins was published in 2002.[1] Its stated aims were to offer acceptable terminology and to avoid confusion for clinical practitioners. Four years on, has it achieved these aims?

The consensus proposed clear descriptive names for the whole range of superficial, deep and perforating veins of the lower limbs, while trying to dispose of eponyms. It provides a valuable reference work for anatomists and helpful consistency for describing the more obscure and variable of the veins.

Its nomenclature for the veins most commonly dealt with by clinicians has been less of a success,

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and has increased confusion and diversity of usage – in English speaking countries at least. The consensus statement dictates a change to from ''long'' to ''great'' saphenous vein – rather illogical since the vein is always long but it may be quite small. The same applies to the short saphenous vein – renamed the lesser saphenous – a shame, because it is always short but it may be very large. It does seem strange that a consensus group which was prepared to take some sensible steps away from Terminologia Anatomica in renaming other veins has sewn such potential for confusion among clinicians by the illogical changes to ''great'' and ''lesser''.

The situation – in the UK if not elsewhere – is now more confused than before the group published its nomenclature statement, although few clinicians seem to have paid much attention to the new names, still using the terms ''long'' and ''short''. The long saphenous vein firmly remains the ''LSV''. The proposed nomenclature needs more debate. How well does it suit vascular specialists in the rest of Europe? Does it matter?

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Reference

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